89-1125

Supreme Court, U.S.
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No.

In The
Supreme Court of the United States
October Term, 1989

THORN APPLE VALLEY, INC.
Petitioner,

v.

AUTO CLUB INSURANCE ASSOCIATION, FORMERLY KNOWN AS DAIIE, SUBROGEE OF: ALI CHEHAB, FAYSAL MASLOUM, HOUHAD JAMIL BAZZI, HUSSEIN E. HABAB, NASRI JOMAA, ALI K. HASHEM, AND SAMI M. ALAOUIE
Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE MICHIGAN COURT OF APPEALS

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QUESTIONS PRESENTED

A. **Whether Section 514 of ERISA, 29 U.S.C. § 1144, preempts a state common law subrogation claim brought to obtain benefits under a self-insured ERISA welfare benefit plan by a non-ERISA party claiming to urge derivatively the plan rights of a plan beneficiary.**

B. **Whether a state common law subrogation claim brought to obtain benefits under a self-insured ERISA welfare benefit plan by a non-ERISA party claiming to urge derivatively the plan rights of a plan beneficiary may be resolved with reference to state law as opposed to the federal standards for resolving ERISA benefit claims articulated in *Firestone Tire and Rubber Co.* v. *Bruch*, 489 U.S. ___ , 109 S.Ct. 948 (1989), and *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41 (1987).**

PARTIES TO THE PROCEEDING

The parties to the proceedings below are listed in the caption. Frederick & Herrud, Inc. is a corporation. It has, since the commencement of this litigation, changed its corporate name to Thorn Apple Valley, Inc.

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In The
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No. _____

FREDERICK & HERRUD, INC.,
Petitioner,

v.

AUTO CLUB INSURANCE ASSOCIATION, FORMERLY KNOWN AS DAIIE, SUBROGEE OF: ALI CHEHAB, FAYSAL MASLOUM, HOUHAD JAMIL BAZZI, HUSSEIN E. HABAB, NASRI JOMAA, ALI K. HASHEM, AND SAMI M. ALAOUIE
Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE MICHIGAN COURT OF APPEALS

Petitioner, Frederick & Herrud, Inc. (Frederick), respectfully prays that a writ of certiorari issue to review the judgment and opinion of the Michigan Court of Appeals entered on March 6, 1989. That decision became final, for purpose of review by this Court, on November 1, 1989, when the Supreme Court of Michigan denied Petitioner's application for leave to appeal.

OPINIONS BELOW

The November 1, 1989 order of the Supreme Court of Michigan is reported at 433 Mich. 900 (1989), and is reprinted at A. 1. The March 6, 1989 decision of the Michigan Court of Appeals is reported at 175 Mich. App. 412 (1989), and is reprinted at A. 2. An earlier decision by the Michigan Court

of Appeals in this case issued on June 10, 1985, is reported at 145 Mich. App. 722 (1985), and is reprinted at A. 14. The orders from the Oakland County (Mich.) Circuit Court, giving rise to the appeals, are not reported and are reprinted at A. 8–13, 25–26.

JURISDICTION

The most recent decision of the Michigan Court of Appeals issued on March 6, 1989, and became final, for purpose of review by this Court, when the Supreme Court of Michigan denied petitioner's application for leave to appeal on November 1, 1989. See *Belknap, Inc.* v. *Hale*, 463 U.S. 491, 497 n.5 (1983). The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1257(a).

STATUTES INVOLVED

This case involves Sections 502 and 514 of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, 29 U.S.C. §§ 1132 and 1144 and Section 3109a of Michigan's No-Fault Insurance Act, Mich. Comp. Laws Ann. § 500.3109a. Pertinent portions of these provisions are reprinted at A. 27–33.

STATEMENT OF THE CASE

This case presents what the lower court recognized were highly important issues, which are likely to recur in future litigation, unless resolved. A.3. It provides the Court with the opportunity to consider and resolve the important questions of whether entities which are not identified as potential plaintiffs in ERISA's civil enforcement section, 29 U.S.C. § 1132, may bring state common law derivative claims for benefits under ERISA welfare benefit plans and whether state law may control the resolution of such derivative benefit claims.

Petitioner Frederick (now known as Thorn Apple Valley, Inc.), is a meat packing company. It employs more than 2,500 employees in approximately 12 states. It sponsors in excess of 15 self-insured and self-administered employee welfare benefit plans. Most of Frederick's plans, in particular the plan involved in this case, were the product of collective bargaining.

Respondent, Auto Club Insurance Association, is a Michigan no-fault insurance company. It paid no-fault benefits on behalf of seven persons who were injured in automobile accidents in 1980 and 1981. In this action, respondent sought reimbursement from Frederick for these benefits by claiming to be subrogated to the rights its seven insureds had under a self-insured employee welfare benefit plan sponsored by their employer, Frederick.

Frederick's plan denied respondent's "subrogation" claims for benefits based upon a specific provision in the plan which states that "in all cases [involving] employees with no-fault auto insurance coverage, the auto insurance carrier will be primary." Following the plan's refusal to reimburse respondent, respondent brought a state court "subrogation" action against Frederick in the Oakland County (Mich.) Circuit Court.

The circuit court initially ruled in 1984 that respondent and Frederick were "in equal priority" with respect to the benefits paid to respondent's seven insureds. The court ordered Frederick to reimburse respondent for 50 percent of the no-fault benefits it had paid. A.25–26. Both parties appealed this ruling to the Michigan Court of Appeals.

In 1985, the Michigan Court of Appeals vacated the circuit court's ruling, and held that the policies underlying Michigan's no-fault insurance law, which requires no-fault insurers "to offer" coordinated automobile insurance to their customers, Mich. Comp. Laws Ann. § 500.3109a, mandated that Frederick be deemed "primary" with respect to the automobile accident losses sustained by its seven employees. The Court of Appeals remanded the case to the circuit

court for "entry of judgment and determination of liability consistent with this opinion." A.24.

Frederick then urged before the circuit court, on remand, that respondent's "subrogation" claims were preempted by ERISA because they "relate to" Frederick's ERISA welfare benefit plan. The circuit court refused to consider preemption, and entered a final judgment imposing 100 percent liability against Frederick for the medical expenses incurred by respondent's seven insureds. A.8. Frederick appealed again to the Michigan Court of Appeals.

On March 6, 1989, the Michigan Court of Appeals expressly undertook to review the merits of preemption, because of the importance and recurring nature of the issue. A.3. The Court rejected Frederick's contention that respondent's subrogation claims were preempted by ERISA. The court relied on the Sixth Circuit's holding in *Northern Group Services, Inc.* v. *Auto Owners Insurance Co.*, 833 F2d 85 (6th Cir. 1987), *cert. denied*, ___ U.S. ___, 108 S.Ct. 1754 (1988), that ERISA does not preempt Mich. Comp. Laws § 500.3109a to the extent that it permits Michigan no-fault carriers to write no-fault automobile insurance policies containing coordination of benefits provisions which conflict with similar provisions in ERISA plans.

The Supreme Court of Michigan subsequently declined to review the decision of the Court of Appeals. A.1.

REASONS FOR GRANTING THE WRIT

This case involves another incursion of state law upon the administration of ERISA welfare benefit plans. This Court has heretofore been especially vigilant in preventing state law incursions in this area, an area which Congress intended would be exclusively a federal concern. The Court previously has prohibited states from regulating the substantive terms of private retirement plans, *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), has prohibited state law from

controlling the adjudication of benefit claims under welfare benefit plans, *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life Insurance Co.* v. *Taylor*, 481 U.S. 58 (1987), has recognized that state mandatory benefit laws may not be applied directly to self-insured welfare benefit plans, *Metropolitan Life Insurance Co.* v. *Massachusetts*, 471 U.S. 724, 735 n.14, 747 (1985) ("We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect [state] regulation where the latter are not"), and has prohibited states from imposing substantive obligations upon welfare benefit plans under state fair employment practices laws when such obligations would not be imposed under federal law. *Shaw* v. *Delta Airlines, Inc.*, 463 U.S. 85 (1983).

Here, parochial policies of the State of Michigan have been employed to force a self-insured ERISA welfare benefit plan to pay benefits, in direct contravention of a specific provision in the plan, to a third party claiming benefits from the plan as a "subrogee" of plan beneficiaries. This intrusion of state law into an area reserved by Congress for federal regulation not only conflicts with decisions of this Court, it disrupts the comprehensive, exclusive and uniform federal procedures established by Congress for resolving benefit claim disputes concerning ERISA plans. See *Firestone Tire and Rubber Co.* v. *Bruch*, 489 U.S. ___, 109 S.Ct. 948 (1989); *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41 (1987).

This case thus presents this Court with an opportunity to resolve a number of difficult and important questions[1] pertaining to the adjudication of ERISA benefit claim disputes, questions over which there are significant conflicts among the circuits and state courts. This is an area where it has

[1] The importance of the issues presented in this case is underscored by the fact that approximately 95% of American workers are participants in employer-sponsored health plans. Wiatrowski, *Comparing employee benefits in the public and private sectors*, reprinted in *U.S. Bureau of Labor Statistics, Department of Labor, Monthly Labor Review*, p.4 (December 1988). The prevalence of no-fault automobile insurance laws across the country also ensures that the issues presented here will have more than mere local implications.

been previously recognized that the need for clarity is especially important. See *Mason* v. *Continental Group, Inc.*, 474 U.S. 1087 (1986) (White, J. and Brennan, J., dissenting from denial of certiorari). That need is shown here by the disruption and uncertainty imposed by the lower court on a lawful benefit program established by Frederick through the process of collective bargaining.

I.

REVIEW IS WARRANTED BECAUSE THE LOWER COURT'S DECISION CONFLICTS WITH DECISIONS OF THIS COURT AND IGNORES THE INTENT OF CONGRESS TO PREEMPT THE FIELD OF EMPLOYEE BENEFIT PLAN REGULATION.

The lower court's ruling directly conflicts with this Court's previous decisions concerning the preemption of state laws and state law claims which "relate to" ERISA plans.

In *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), the Court rejected a similar state effort to alter the substantive benefits provided by an employee benefit plan. The Court held that a provision in a state's workers compensation statute, which had the effect of invalidating a set-off provision in a retirement plan, "related to" the plan and was therefore preempted by ERISA. The Court noted, in *Alessi*, that, in addition to the local statute's incursion upon matters which ERISA is designed to regulate, the statute also altered a benefit which had been the product of collective bargaining under the Labor Managment Relations Act. Both factors compelled a finding of preemption there. *Id.* at 523–26.

Both of these factors are likewise present here. The decision of the Michigan Court of Appeals has the effect of invalidating a specific provision in Frederick's welfare benefit plan, by making the plan primary when the plan expressly provides it will be secondary. It also has the effect of significantly

altering a benefit program which was the product of collective bargaining.

The Michigan Court of Appeals ruled, in spite of the fact that respondent's state law "subrogation" claims "relate to" Frederick's welfare benefit plan, that the claims are nonetheless "saved" from preemption since they emanate from Michigan's no-fault insurance law which is a law which "regulates insurance" under Section 514(b)(2)(A) of ERISA. 29 U.S.C. § 1144(b)(2)(A). The court's holding conflicts with decisions of this court and ignores the will of Congress in at least three respects:

1. No less than the common law tort and contract claims for benefits this Court held were preempted by ERISA in *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41 (1987), and *Metropolitan Life Insurance Co.* v. *Taylor*, 481 U.S. 58 (1987), respondent's common law subrogation claim for benefits here has "roots firmly planted in the general principles of" Michigan common law. 481 U.S. at 50. In this regard subrogation is not an insurance doctrine in Michigan. It was formulated in noninsurance cases, e.g., *Kelly* v. *Kelly*, 54 Mich 30, 19 N.W. 580 (1884), and only years later was adapted to resolve priority of coverage disputes between insurance companies. E.g., *Detroit Automobile Inter-Insurance Exchange* v. *Detroit Mutual Automobile Insurance Co.*, 337 Mich. 50, 59 N.W.2d 80 (1953); *Allstate Insurance Co.* v. *Snarski*, 174 Mich. App. 148, 435 N.W.2d 408 (1988), lv.den., 432 Mich. 883 (1989). Thus respondent's subrogation claim is not an "insurance" claim and the insurance "savings" clause is inapplicable.

2. The lower Court's decision also conflicts with this Court's decision in *Metropolitan Life Insurance Co.* v. *Massachusetts*, 471 U.S.724 (1985), by subjecting the terms of Frederick's plan to state regulation when Congress ordained they would be exempt. In ERISA's "deemer" clause, Congress mandated that such a plan cannot be "deemed to be an insurance company or other insurer . . . for purposes of any law of any state purporting to regulate insurance." 29 U.S.C. § 1144(b)(2)(B). This creates a distinction between insured plans, which may

be indirectly regulated under state insurance laws, and self-insured plans, such as Frederick's plan, which are entirely exempt from all state regulation. This Court has previously recognized that this distinction was created by Congress and that Congress has intentionally chosen not to alter it. *Metropolitan Life Insurance Co.* v. *Massachusetts*, 471 U.S. 724, 747 (1985). The ruling of the Michigan Court of Appeals in this case repudiates *Metropolitan Life*, and subjects Frederick's self-insured plan to direct state regulation in contravention of the mandate of Congress that it be exempt from state regulation.

3. Contrary to the lower court's decision, there is nothing conditional or qualified about the "deemer" language in Section 514 of ERISA. It categorically provides that an employee benefit plan shall not be "deemed to be an insurance company" for purposes of any state law purporting to regulate insurance. This straight-forward expression of congressional intent should be strictly enforced, not enforced, as here, only when a state court, after considering parochial and local concerns, chooses to apply it. The lower court's attempt to balance the federal interest in uniform regulation of employee benefit plans against federal policies favoring state regulation of the insurance industry is thus entirely misconceived.

II.

REVIEW IS WARRANTED TO RESTORE AND EFFECTUATE THE INTENT OF CONGRESS TO PREEMPT THE FIELD OF CLAIM DISPUTE ADJUDICATION CONCERNING EMPLOYEE BENEFIT PLANS.

In this case, the Court is presented with the opportunity to restore federal law to the primacy Congress intended in the adjudication of benefit claim disputes concerning ERISA plans.

In *Pilot Life*, this Court confirmed that the comprehensive and exclusive civil enforcement scheme of Section 502 is one of the essential tools for accomplishing the stated purpose of ERISA. 481 U.S. at 52. Thus, Section 502 creates, among other things, a civil action to enforce benefit rights under ERISA plans. 29 U.S.C. § 1132(a)(1)(B). This Court has held that the remedies enumerated by Congress in Section 502 are exclusive, and may not be contradicted or supplemented by judge-made federal or state remedies. *Pilot Life Insurance Co.* v. *Dedeaux*, 481 U.S. 41 (1987); *Massachusetts Mutual Life Insurance Co.* v. *Russell*, 473 U.S. 134 (1985). Only nonsubstantive procedural devices, such as state garnishment remedies, have *ever* been permitted by this Court to be used to assert state law claims directly against ERISA plans. See *Mackey* v. *Lanier Collections Agency & Service, Inc.*, 486 U.S. ___, 108 S.Ct. 2182 (1988).

Respondent's subrogation claim against Frederick is clearly more than a nonsubstantive procedural device. Unlike a state garnishment, which is merely a device to collect a debt owed by a plan beneficiary without altering his substantive benefit rights under the plan, the lower Court's decision here allows a purported "subrogee" to urge derivatively the substantive benefit rights of his subrogor *and* to alter those rights with reference to state law. Here it was used by respondent to force Frederick to pay substantive benefits under its plan in contravention of a provision in the plan which states that benefits are not payable.

Respondent's subrogation claim is inevitably intertwined with the plan rights of the plan beneficiaries whose rights respondent seeks derivatively to urge. Under Michigan law, as in other states, a subrogee merely "stands in the shoes of the subrogor and acquires no greater rights than those prossessed by the subrogor." *Federal Kemper Insurance Co.* v. *Isaacson*, 145 Mich. App. 179, 182, 377 N.W.2d 379, 381 (1985); see also *Home Insurance Co.* v. *Rosquin*, 90 Mich. App. 682, 282 N.W.2d 446 (1979), lv. den. 408 Mich. 855 (1980); *Federal Kemper Insurance Co.* v. *The Western Insurance*

Companies, 97 Mich. App 204, 293 N.W.2d 765 (1980). The Michigan Court of Appeals has implicitly recognized and applied this principle in adjudicating disputes between no-fault insurers and medical plans, similar to the dispute involved here, by holding that a no-fault insurer, such as respondent, seeking reimbursement from a health plan for no-fault benefits paid to a plan beneficiary, is bound just as if it were a plan beneficiary itself by the specific conditions, limitations or restrictions set forth in the plan. *Calhoun* v. *Auto Club Insurance Association*, 177 Mich. App. 85, 441 N.W.2d 54 (1989) (HMO's designation of exclusive health care providers was binding on no-fault insurer seeking reimbursement for funds paid to nondesignated providers).

The lower court here, however, went much further than merely allowing respondent to "stand in the shoes" of its "subrogors." It invalidated under state law a specific provision in the Frederick plan which states that benefits are not payable when, as here, a plan beneficiary has other insurance. Thus, the effect of the lower court's ruling is to accord persons urging derivatively the benefit rights of ERISA plan beneficiaries rights under state law that the beneficiaries themselves do not have.

Benefit claims under ERISA plans are and should be governed exclusively by ERISA's exclusive civil enforcement provision, not by an uncertain patchwork of state insurance laws or common law claims. Benefit claims and the standards of judicial review of claim decisions are (and should be) necessarily federal in nature. *Metropolitan Life Insurance Co.* v. *Taylor*, 481 U.S. 58, 67 (1987); see also *Firestone Tire and Rubber Co.* v. *Bruch*, 489 U.S. ___ , 109 S.Ct. 948 (1989). As one federal circuit has recognized, the clear intent of Congress in enacting ERISA's civil enforcement and preemption provisions was not merely to permit ERISA benefit claims to "absorb" local state law doctrines and remedies; rather it was that state doctrines and remedies in benefit disputes be wholly displaced by federal law. *Amos* v. *Blue Cross-Blue*

Shield of Alabama, 868 F.2d 430 (11th Cir.), cert. denied, ___ U.S. ___, 110 S.Ct. 158 (1989).

One practical effect of the decision by the Michigan Court of Appeals here is that what are essentially derivative claims for benefits under welfare benefit plans may now be resolved with reference to an uncertain patchwork of state "insurance" laws and common law subrogation doctrines. Whether or not Congress intended to subject insured ERISA plans to such variations in state law may be open to debate among reasonable people; it is not now similarly open to debate that Congress intended to exempt self-insured plans from such state law variations. *Metropolitan Life Insurance Co.* v. *Massachusetts*, 471 U.S. 724, 747 (1987).

It should come as no surprise to anyone that the parochial interests of local automobile insurers in Michigan won out over federal interests in a contest in the Michigan courts, and that such local interests will invariably win out in other states as well, if such a deviation from the intent of Congress and the will of this Court is permitted to remain and take root. Congress's intent that there be uniform procedural and substantive rules for resolving disputes over the administration of ERISA plans will be thereby wholly frustrated, particularly for employers such as Frederick which face the unenviable prospect of administering benefit plans in numerous states having uncertain and perhaps conflicting insurance laws and other common law doctrines.

III.

REVIEW IS WARRANTED TO RESOLVE CONFLICTS AND UNCERTAINTY CONCERNING THE VIABILITY AND RESOLUTION OF DERIVATIVE CLAIMS FOR BENEFITS UNDER EMPLOYEE BENEFIT PLANS.

This case highlights and exacerbates direct conflicts among the circuits regarding the viability of derivative claims for benefits under ERISA plans and the resolution of those claims. At least two circuits, the Fifth and the Ninth, have squarely

ruled that ERISA benefit rights may be assigned, and that a third party "assignee" may bring a derivative benefit collection action directly under Section 502 of ERISA. *Hermann Hospital* v. *MEBA Medical & Benefits Plan*, 845 F.2d 1286 (5th Cir. 1988); *Misic* v. *Building Service Employees Health & Welfare Trust*, 789 F.2d 1374 (9th Cir. 1986); see also *Wisconsin Department of Health and Human Services* v. *Upholsterers International Union Health and Welfare Fund*, 686 F. Supp. 708 (W.D. Wisc. 1988). The Third Circuit has reached the opposite conclusion. *Northeast Department ILGWU Health and Welfare Fund* v. *Teamsters Local Union No. 229 Welfare Fund*, 764 F.2d 147, 154 n.6 (3rd Cir. 1985); see also *Nationwide Mutual Insurance Co.* v. *Teamsters Welfare Fund of Philadelphia and Vicinity*, 695 F. Supp. 181, 184 (E.D. Pa. 1988).

Here, the lower court has permitted respondent to bring another form of derivative claim for benefits under an ERISA plan under state law, and has permitted state law to control the resolution of that claim. This latter result represents an unprecedented incursion of state law upon an area which Congress ordained, and as this Court has frequently reminded, is "exclusively a federal concern." *Shaw* v. *Delta-Airlines, Inc.*, 463 U.S. 85, 98-99 (1983).

Whichever way this Court resolves the conflict in the circuits concerning the *validity* of bringing derivative claims for ERISA benefits under Section 502, we respectfully submit that *any* rule which permits, as did the lower court here, a state court to resolve such claims with reference to state law will inevitably frustrate the intent of Congress that there be uniform federal procedural and substantive rules governing the resolution of ERISA benefit disputes. See *Amos* v. *Blue Cross-Blue Shield of Alabama*, 868 F.2d 430 (11th Cir.) cert. denied, ___ U.S. ___, 110 S.Ct. 158 (1989).

The lower court's ruling also creates an unintended exception to the rule that remedies under ERISA are exclusively federal, and may not be contradicted or supplemented by state remedies. See *Pilot Life Insurance Co.* v. *Dedeaux*, 481

U.S. 41 (1987); *Massachusetts Mutual Life Insurance Co.* v. *Russel*, 473 U.S. 134 (1985). In effect the lower Court's decision allows anyone seeking to circumvent ERISA's exclusive remedies and procedures, and instead to rely on more expansive or even punitive state law remedies, the option of merely contriving a transfer of his benefit rights to a third party. The congressional policy favoring uniformity in the adjudication of ERISA benefit claims can thereby be completely evaded.

IV.

REVIEW IS WARRANTED TO RESOLVE CONFLICTS AND UNCERTAINTY IN THE LAW GOVERNING THE RESOLUTION OF DISPUTES OVER LIABILITY BETWEEN ERISA PLANS AND NON-ERISA ENTITIES.

This case is an appropriate vehicle for resolving the growing controversy among the circuits, and state courts, concerning the law governing disputes between ERISA plans and other parties, including tortfeasors and insurance companies. At least two circuits, the Ninth and the Eighth, have ruled that ERISA preempts the application of state "anti-subrogation" laws to ERISA welfare benefit plans so as to prevent such plans from pursuing claims against third party tortfeasors or insurance carriers providing parallel or duplicating compensation or benefits to plan beneficiaries. *Baxter* v. *Lynn*, 886 F.2d 182 (8th Cir. 1989); *United Food & Commercial Workers & Employers Arizona Health & Welfare Trust* v. *Pacyga*, 801 F.2d 1157 (9th Cir. 1986); see also *Davis* v. *Line Construction Benefit Fund*, 589 F. Supp. 146 (W.D. Mo. 1984); *Hunt* v. *Sherman*, 345 N.W.2d 750 (Minn. 1984). The Third Circuit, however, has again reached a contrary conclusion. *FMC. Corp.* v. *Holliday*, 885 F.2d 79 (3rd Cir. 1989); see also *Allstate Insurance Co.* v. *The 65 Security Plan*, 879

F.2d 90 (3rd Cir. 1989); *Buehler Ltd.* v. *Home Life Insurance Co.*, ___ F.Supp. ___, 11 E.B.C. Cases 2042 (N.D. Ill. 1989). Similarly here, the lower court, applying state law only, has vitiated a provision in the Frederick plan which excluded coverage for losses covered by other insurance.

As in those cases where ERISA plans have attempted affirmatively to seek restitution for benefits paid to plan beneficiaries from others who may be responsible for paying duplicating benefits or compensation, the Frederick plan here has attempted to enforce a plan provision which takes into consideration benefits obtainable from other sources. There is nothing inappropriate — under ERISA — in this attempt. State interference with the administration of such permissible plan provisions, either through the enforcement of "anti-subrogation" laws or through the adjudication of third party "subrogation" claims dependent upon state law *against* the plans or the employers sponsoring the plans, frustrates Congress's purpose of providing uniform rules for the determination of ERISA benefit rights.

The lower court's ruling here illustrates precisely how state law can be used directly to circumvent congressional intent by forcing an ERISA plan to pay benefits in direct contravention of a specific provision in the plan which states that benefits are not payable. Given that these issues are presented here in a fully litigated context, we respectfully submit that this case would provide an appropriate vehicle for this Court to decide them.

V.

REVIEW IS WARRANTED TO RESOLVE THE CONFLICT AMONG THE CIRCUITS CONCERNING THE RESOLUTION OF DISPUTES BETWEEN WELFARE BENEFIT PLANS AND NO-FAULT AUTOMOBILE INSURERS.

The law in this area, particularly as it has developed in the Sixth Circuit, is uncertain, conflicting, and in dire need of

resolution by this Court. The importance and recurring nature of the issues presented in this case was recognized by the lower court, and is confirmed by the fact that in the past two years, this Court has been asked to decide some of them on at least three occasions. See *Northern Group Services, Inc. v. State Farm Mutual Automobile Insurance Co.*, ____U.S. ____, 108 S Ct. 1754 (1988); *Central States, Southeast and Southwest Areas Health and Welfare Fund v. Hawkeye Security Insurance Co.*, ____ U.S. ____ 109 S.Ct. 783 (1989); *Windstead v. Indiana Insurance Co.*, ____ U.S. ____, 109 S.Ct. 971 (1989).

Now, in contrast with previous cases, the Court has the opportunity to review these issues in the context of a fully litigated case, rather than an abstract declaring judgment action, and with the benefit of subsequent decisions by the appellate courts, which have only established more conflicts and more confusion in the area. In this regard, a decision by this Court that coverage disputes between ERISA plans and insurance carriers (or other entities) should be litigated as derivative claims for plan benefits under Section 502 of ERISA, as such claims truly are, would eliminate the uncertainty and effectuate congressional intent that there be uniform federal rules governing the enforcement of benefit rights under ERISA plans.

In the context of an abstract declaratory judgment action brought by several ERISA plans against an array of no-fault insurers which were then threatening to bring claims for "reimbursement" against the plans under Michigan law, the Sixth Circuit ruled, in *Northern Group Services, Inc.* v. *Auto Owners Insurance Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, ___ U.S. ___ , 108 S.Ct. 1754 (1988), that ERISA did not preempt Michigan law to the extent that it would require an ERISA plan to accept primary liability when both the no-fault insurance policy and the ERISA plan contain "coor-

dination of benefits" language.[4] The court ruled that Michigan law was not preempted even when applied to self-insured ERISA plans. Notwithstanding the specific language in the "deemer" clause to the effect that ERISA plans shall not be "deemed" to be insurance carriers for purposes of state insurance laws, the court ruled that ERISA plans may be deemed to be insurance carriers under state insurance laws dealing with priority of coverage.

The Sixth Circuit's emasculation of the "deemer" clause in *Northern Group Services*, by allowing state regulation of self-insured ERISA plans under the guise of insurance regulation, finds no support of which we are aware in any decision by this Court, cf. *Metropolitan Life Insurance Co.* v. *Massachusetts*, 471 U.S. 724, 747 (1985), or in the pertinent legislative history.[5] It cannot be reconciled with decisions in the Ninth and Seventh circuits — or with a more recent decision by the Sixth Circuit itself.

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[4] The Sixth Circuit's assertion of jurisdiction to consider preemption in *Northern Group Services* conflicts with the position of the Third Circuit that there is no federal jurisdiction over these disputes. If the Third Circuit is correct in *Allstate Insurance Co.* v. *The 65 Security Plan*, 879 F.2d 90 (3rd Cir. 1989), that there is no federal jurisdiction over derivative claims for ERISA plan benefits similar to those which were only threatened in *Northern Group Services*, then it is doubtful that the Sixth Circuit in *Northern Group Services* even had jurisdiction to rule on the question of preemption. See *Skelly Oil Co.* v. *Phillips Petroleum Co.*, 339 U.S. 667, 673 (1950); *Public Service Commission of Utah* v. *Wycoff Co.*, 344 U.S. 237, 248 (1952).

[5] Mindful that reliance upon after-the-fact legislative history may be risky, there is ample evidence that Congress never intended the "deemer" clause to be construed as less than categorical. The 1977 Activity Report of the House Committee on Education and Labor states that the "deemer" language creates an "irrebutable presumption" that ERISA plans are not insurance companies for purposes of state insurance laws, a presumption which "cannot be overcome even if an employee benefit plan engages in actions which bring it within the insurance . . . activities regularly regulated by a state." ERISA Oversight Report of the Pension Task Force of the Subcommittee on Labor Standards, House Committee on Education and Labor, p. 10 (1977). Moreover, in 1986, Congress found it necessary specifically to amend Section 514 of ERISA to exempt from preemption a narrow category of state coordination of benefits laws (i.e., those designed to comply with the Social Security Act). 29 U.S.C. § 1144(b)(8). This also evidences that Congress, at least, has recognized that the application of other forms of state coordination of benefits laws to ERISA plans should be preempted.

In *Kanne* v. *Connecticut General Life Insurance Co.*, 867 F.2d 489 (9th Cir. 1988), the Ninth Circuit held that a cause of action against an ERISA plan inferred from a provision in California's Insurance Code prohibiting "unfair insurance practices" was preempted under the rationale of this court's decision in *Pilot Life*. This Court recently decline to review *Kanne*. ___ U.S. ___, 109 S.Ct. 3216 (1989). Although *Kanne* involved a direct claim by a plan beneficiary, rather than derivative claim by a party seeking to assert the benefit rights of a plan beneficiary, the facts in *Kanne* are analytically indistinguishable from those in the case at bar: Both involve state claims against ERISA plans ostensibly inferred from provisions in a state's insurance laws. The findings of preemption in *Kanne* and of no preemption here cannot be reconciled.

Furthermore, in *Winstead* v *Indiana Insurance Co.*, 855 F.2d 430 (7th Cir. 1988), *cert. denied*, ___ U.S. ___, 109 S.Ct. 839 (1989), the Seventh Circuit ruled in circumstances identical to those presented in this case that liability arising out of a Michigan automobile accident should be apportioned, as a matter of "federal common law," on a *pro rata* basis between the no-fault insurer and the ERISA plan.

Finally, there is now significant division within the Sixth Circuit, which the Sixth Circuit has declined to resolve by *en banc* consideration, concerning the preemption of derivative claims for benefits under ERISA plans. The Sixth Circuit recently ruled in *Liberty Mutual Insurance Co.* v. *Iron Workers Health Fund of Eastern Michigan*, 879 F.2d 1384 (6th Cir. 1989), that ERISA does preempt, after all, the application of Michigan law in an action by a no-fault insurance carrier seeking reimbursement from an ERISA plan which unconditionally "excluded" coverage, rather than merely providing for secondary coverage, in automobile accidents. There is no suggestion whatsoever in the statutory text, or in the legislative history, that in enacting Section 514 of ERISA Congress intended that the preemption of a state claim brought against an ERISA plan would turn on a court's review and

analysis of substantive provisions in the plan. Nor is there any evidence, of which we are aware, that Congress intended to encourage the adoption of more restrictive or less comprehensive benefits in ERISA welfare benefit plans. Yet, the natural and foreseeable consequence of the case at bar, *Iron Workers* and *Northern Group Services* is the encouragement of the adoption of flat as opposed to conditional automobile accident exclusions by plan sponsors and administrators. The fact that these decisions may ultimately affect unnecessarily the benefit rights of employees throughout the country warrants this Court's attention at this time, before further confusion and conflicts develop and cause further detriment to both employees and employers.

CONCLUSION

For the foregoing reasons, the petition for writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

MICHIGAN SUPREME COURT
Lansing, Michigan

Order
Entered: November 1, 1989

AUTO CLUB INSURANCE ASSOCIATION,
formerly known as DAIIE, Subrogee of: Ali Chehab, Faysal Masloum, Houhad Jamil Bazzi, Hussein E. Habab, Nasri Jomaa, Ali K. Hashem, and Sami M. Alaouie,
Plaintiff-Appellee,

v

FREDERICK & HERRUD, INCORPORATED,
a corporation,
Defendant-Appellant.

SC: 85771
COA: 96693
LC: 82-246269-CK

On order of the Court, the application for leave to appeal is considered, and it is DENIED, because we are not persuaded that the questions presented should be reviewed by this Court.

I, CORBIN R. DAVIS, Clerk of the Michigan Supreme Court, certify that the foregoing is a true and complete copy of the order entered at the direction of Court.

November 1, 1989

Jacqueline B. MacKinson
Deputy Clerk

STATE OF MICHIGAN

COURT OF APPEALS

AUTO CLUB INSURANCE ASSOCIATION,
Plaintiff-Appellee,

March 6, 1989

v

No. 96693

FREDERICK & HERRUD, INCORPORATED,
Defendant-Appellant.

Before: GRIBBS, P.J., and MAHER and J.L. BANKS,* JJ.

J.L. BANKS J. Defendant appeals as of right from a judgment entered in favor of plaintiff on November 3, 1986, and from interlocutory orders denying defendant's motion for leave to file a first amended answer and denying defendant's motion for summary disposition.

This is the second time this case is before this Court. The facts are detailed in *Auto Club Ins Ass'n v Frederick & Herrud, Inc*, 145 Mich App 722; 377 NW2d 902 (1985). This litigation involves a dispute between plaintiff and defendant as to which of them shall bear primary responsibility for medical and related expenses incurred by seven employees of defendant. These employees were covered by no-fault insurance policies issued by plaintiff. In our prior decision, we reversed the lower court's order holding each party responsible for payment of one-half the benefits owed to the insureds. 145 Mich App 734. Based on our review of the legislative history behind MCL 500.3109a; MSA 24.13109(1), we concluded that the Legislature, in providing that no-fault insurers were required to offer coordination of benefits options to their insureds, intended the health and accident insurance coverage to be primary and the no-fault coverage to be secondary. 145 Mich App 727–732.[1] We remanded this case for entry of judgment and determination of liability consistent with our opinion. 145 Mich App 734.

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* Circuit judge, sitting on the Court of Appeals by assignment.

[1] Our construction of the statute on this issue was approved and adopted by the Michigan Supreme Court in *Federal Kemper Ins Co, Inc v Health Ins Administration, Inc*, 424 Mich 537, 383 NW2d 590 (1986).

Following remand to the circuit court, defendant moved for leave to amend its answer to add the affirmative defense that plaintiff's state claim was preempted by the Employee Retirement Income Security Act (ERISA), 29 USC 1144(a). The circuit court denied the motion to amend, finding no newly discovered facts and undue delay in bringing the motion. Defendant then moved for summary disposition, asserting that ERISA deprived the state court of subject matter jurisdiction over the dispute.The circuit court denied defendant's motion for summary disposition and entered judgment for plaintiff in the amount of $27,911.33 (reimbursement in the amount of $16,560 plus statutory interest and costs).

In this appeal defendant asserts that the trial court erred in denying its motion to amend its answer and in denying its motion for summary disposition. Defendant additionally argues that plaintiff's state claim is preempted by ERISA. While the circuit court did not consider the merits of the issue, and while ordinarily this Court will not review issues not first considered by the trial court, we choose to review the merits of the preemption issue. Our election to review this issue is made in the interests of justice, in recognition of the importance of the issue and the probability that it will again arise in future litigation, and because our decision on this issue renders moot the other issues presented in this appeal. *DeWitt Twp v Clinton Co*, 113 Mich App 709, 713; 319 NW2d 2 (1982).

Section 514(a) of ERISA provides:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975. [29 USC 1144(a).]

It is undisputed that defendant's employee benefit plan[2] is a plan within the broad scope of ERISA and subject to § 514(a). However, under ERISA, certain types of state laws are "saved" from federal preemption:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities. [29 USC 1144(b)(2)(A).]

The Michigan no-fault insurance act is a state act which regulates insurance. However, the saving clause of 29 USC 1144(b)(2)(A) is limited by 29 USC 1144(b)(2)(B), commonly called the "deemer" clause, which provides:

> Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

Defendant argues that its employee benefit plan is a self-funded plan, i.e., the benefits are paid by the plan itself without involvement by an outside insurance company and that as a self-funded plan it is not subject to the insurance laws of Michigan and accordingly is not "saved" from preemption under 514. Defendant's construction of the ERISA

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[2] Defendant suggests that plaintiff, by filing suit against defendant corporation instead of the employee benefit plan, has sued the wrong party. Defendant, by failing to timely or properly raise this issue in the trial court, has waived any objection to being named as party defendant. *Kotesky v Davis*, 355 Mich 536, 540; 94 NW2d 796 (1959). Furthermore, it is not necessarily correct that the corporation was not a proper defendant. *Ombrello v Montgomery Ward Long Term Disability Trust*, 163 Mich App 816, 824; 415 NW2d 658 (1987), lv den 430 Mich 854 (1988).

preemption, saving, the deemer clauses was adopted by a panel of this Court in *State Farm Mutual Automobile Ins Co v C A Muer Corp*, 154 Mich App 330; 397 NW2d 299 (1986). One of the cases cited in *C A Muer Corp was Northern Group Services, Inc v State Farm Mutual Automobile Ins Co*, 644 F Supp 535 (ED Mich, 1986). Subsequent to issuance of the panel's decision in *C A Muer Corp*, the Sixth Circuit Court of Appeals issued its opinion in *Northern Group Services, Inc* v *Auto-Owners Ins Co*, 833 F2d 85 (CA 6, 1987), cert den — US —; 108 S Ct 1754; 100 L Ed 2d 216 (1988), reversing the Eastern District Court's decision.

The precise issue presented in *Northern Group Services* was whether § 3109a of the Michigan no-fault automobile insurance act, which requires coordination of benefits and state court interpretation of the provision making no-fault coverage secondary to other health and accident coverage, is preempted by conflicting ERISA provisions. In order to determine whether the Michigan law "regulates insurance" and thus falls within the saving provision, the Sixth Circuit followed the analysis set forth in *Metropolitan Life Ins Co v Massachusetts*, 471 US 724; 105 S Ct 2380; 85 L Ed 2d 728 (1985), and *Pilot Life Ins Co v Dedeaux*, 481 US 41; 107 S Ct 1549; 95 L Ed 2d 39 (1987), which requires examination of whether the practice at issue falls within the meaning of "business of insurance" covered by the *McCarran-Ferguson Act* 15 USC 1011 *et seq*. That analysis requires consideration of three criteria: (1) whether the practice has the effect of transferring or spreading a policyholder's risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice is limited to entites within the insurance industry. *Northern Group Services*, 833 F2d 90. The circuit court concluded that the Michigan coordination of benefits law "regulates insurance" and is therefore encompassed by the saving clause. *Id.*

The Sixth Circuit next examined the applicability of the deemer clause to a self-insuring ERISA plan. Specifically,

the court considered whether the deemer clause barred state regulation of coordination of benefits under a self-insured plan. 833 F2d 91. The court found that the deemer clause should not be construed as barring all state regulation of self-insured plans per se, but rather, resolution of the issue required consideration of the congressional intent behind the deemer clause, the federal interest in uniformity of administration of ERISA plans, the national policy favoring state primacy in the regulation of insurance, and the legislative intent behind the Michigan statutory benefits provision. The court held:

> Our reading of the savings and deemer clauses thus requires at a minimum that, for the deemer clause to override the savings clause in a given case, there must be some ERISA interest in uniformity to outweigh the McCarran-Ferguson interest in state regulation of insurance. When, as here, there is no demonstrated interest in national uniformity and preemption of state law would substantially disrupt a state regulatory scheme generally applicable to both insured and self-insured ERISA plans, as well as to insurers generally, the deemer clause does not bar regulation. To this limited degree, self-insured ERISA plans so regulated are not excluded from the savings clause by the deemer clause; they are thus subject to state insurance regulation pursuant to the savings clause. The Michigan no-fault coordination of benefits rule is the type of insurance regulation of an ERISA plan that is not barred by the deemer clause. [833 F2d 95.]

We believe the Sixth Circuit's construction of the pertinent ERISA provisions is persuasive and, as a federal court construing federal law, its decision is controlling precedent. Defendant asserts it should have been given the opportunity to plead as a defense that plaintiff's claim for reimbursement in accordance with the Michigan coordination of benefits scheme is preempted by conflicting ERISA provisions.

Plaintiff's claim, however, is not preempted. *Northern Group Services, Inc*, 833 F2d 95.

Our decision in this case renders it unnecessary to consider the other issues raised on appeal. We affirm the circuit court's judgement entered in favor of plaintiff.

Affirmed.

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

AUTO CLUB INSURANCE ASSOCIATION, Subrogee of: Ali Chehab, Faysal Masloum, Houhad Jamil Bazzi; Hussein E. Habab; Nasri Jomaa; Ali K. Hashem; and Sami M. Alaouie
Plaintiffs

vs.

FREDERICK & HERRUD, INCORPORATION,
a corporation
Defendant

Case No. 82-246269-CK

Hon. Frederick C. Ziem

ORDER OF JUDGMENT

At a session of said Court held in Pontiac, County of Oakland, State of Michigan ON NOVEMBER 3, 1986

PRESENT: HON. _____
CIRCUIT COURT JUDGE

IT IS HEREBY ORDERED that judgment in the amount of $16,560.00 shall be entered in favor of the Plaintiff herein. Pre judgment interest costs in the amount of $11,311.33 (calculated at 12%) shall also be awarded to Plaintiff. Court costs in the amount of $40.00 shall be awarded to Plaintiff.

IT IS THEREFORE ORDERED that a judgment in the amount of $27,911.33 is hereby granted to Plaintiff.

/s/ FREDERICK C. ZIEM
Circuit Court Judge

Approved as to form:

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

AUTO CLUB INSURANCE ASSOCIATION, formerly known as DAIIE, Subrogee of: ALI CHEHAB, FAYSAL MASLOUM, HOUHAD JAMIL BAZZI; HUSSEIN E. HABAB; NASRI JOMAA; ALI K. HASHEM; and SAMI M. ALAOUIE
Plaintiffs

vs.

FREDERICK & HERRUD, INCORPORATED,
a corporation
Defendant.

Case No.
82-246269-CK

Hon.
Frederick C. Ziem

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ORDER DENYING DEFENDANT'S MOTION FOR SUMMARY DISPOSITION FOR LACK OF SUBJECT MATTER JURISDICTION AND GRANTING PLAINTIFF'S MOTION FOR ENTRY OF JUDGMENT

At a session of said Court held in the Courthouse in the City of Pontiac, County of Oakland, State of Michigan on October 24, 1986

PRESENT: HON. FREDERICK C. ZIEM

Plaintiff having filed a Motion for Entry of Judgment along with a supporting Brief; Defendant having opposed this Motion and having additionally filed a Motion for Summary Disposition for lack of subject matter jurisdiction together with an Affidavit, Exhibits and a supporting Brief; Plaintiff having filed a response to Defendant's Motion for Summary Disposition; and the Court having heard and considered the arguments of counsel on October 1, 1986;

IT IS HEREBY ORDERED that, for the reasons stated by the Court from the bench on October 2, 1986, Defendant's Motion for Summary Disposition for lack of subject matter jurisdiction is hereby denied and Plaintiff's Motion for Entry of Judgment is hereby granted.

/s/ FREDERICK C. ZIEM
FREDERICK C.ZIEM

Approved as to form:

/s/ JOHN WESLEY KLINE
JOHN WESLEY KLINE (P33150)
Attorney for Plaintiffs

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

AUTO CLUB INSURANCE ASSOCIATION, Subrogee of: Ali Chehab; Faysal Masloum; Houhad Jamil Bazzi; Hussein E. Habab; Nasri Jomaa; Ali K. Hashem; and Sami M. Alaquie
Plaintiffs

vs.

FREDERICK & HERRUD, INCORPORATED,
a Corporation
Defendant

Case No.
82-246269-CK

Hon.
Frederick C. Ziem

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ORDER DENYING MOTION FOR LEAVE TO FILE FIRST AMENDED ANSWER AND NOTICE OF AFFIRMATIVE DEFENSES

At a session of said Court held in the City of Detroit, County of Wayne, and State of Michigan on April 11, 1986

PRESENT: HON. _____
CIRCUIT COURT JUDGE

This matter having come on for hearing on Defendant's Motion for Leave tp file First Amended Answer & Notice of Affirmative Defenses, the Court having heard arguments of the parties regarding same, and the Court having found that there was undue delay on the part of the Defendant in making said request for late filing;

IT IS THEREFORE ORDERED that the Motion for Leave to File First Amended Answer and Notice of Affirmative Defenses filed by the Defendant be denied.

/s/ FREDERICK C. ZIEM
CIRCUIT COURT JUDGE

Approved as to form:

/s/ BRADLEY T. RAYMOND
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Attorney for Defendant

Drafted by:

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STATE OF MICHIGAN

COURT OF APPEALS

AUTO CLUB INSURANCE ASSOCIATION, formerly known as D.A.I.I.E., Subrogee of Ali Chehab; Faysal Mazloum; Nouhad Jamil Bazzi; Hussein H. Habab; Nasri Jomaa; Ali K. Hashem; and Sami M. Alaouie,
Plaintiff-Appellee,

September 16, 1985

No. 79289

v

FREDERICK AND HERRUD, INC., a corporation,
Defendant-Appellant.

Before: DANHOF, CJ., and R.B. BURNS and V. J. BRENNAN, JJ.

DANHOF, C.J. Defendant appeals as of right from the order of summary judgment entered on June 25, 1984, declaring that plaintiff and defendant were equally responsible for the payment of no-fault benefits to their respective insureds. Plaintiff cross-appeals.

On August 25, 1982, plaintiff brought suit against defendant, alleging that seven named insureds were each insured under a no-fault insurance contract issued by it, which contracts contained "coordination-of-benefits" clauses. Plaintiff was obligated to pay medical benefits for injuries resulting from auto accidents involving the insureds unless the insureds were covered by another source which provided medical benefits. Each insured was also covered by a contract of accident insurance from defendant, which contract specifically provided that it would pay medical benefits for accidental injuries unless the insureds were covered by no-fault insurance, in which case no-fault would be primary.

In its complaint, plaintiff averred that during 1980–1981, each of the insureds sustained injuries in auto accidents and that claims for medical benefits were made against both plaintiff and defendant. According to plaintiff, both it and defendant

denied the claims on the basis that other insurance was available. Plaintiff asserted that, despite the fact that it was not liable for benefits pursuant to the terms of its contracts, it paid the insureds an aggregate of $11,177.15 in benefits and demanded reimbursement from defendant, but defendant refused such. Plaintiff requested that the trial court enter a declaratory judgment that defendant was responsible for payment in the amount noted above.

Defendant answered the complaint, contending that under its insurance contract it was not responsible for the payment of benefits when there was applicable primary auto insurance coverage, such as plaintiff's, available at the time of the claim.

Defendant moved for summary judgment pursuant to GCR 1963, 117.2(1) [now MCR 2.116(C)(8)], but argued its motion under both 117.2(1) and 117.2(3). The trial court determined that neither party was entitled to a judgment that the other party was solely responsible for the payment of benefits. Rather, the trial court determined that, because both contract provisions were unambiguous, the only proper remedy would be to hold each party responsible for the payment of one-half the benefits owed to the insureds. An order of summary judgment to this effect was entered on June 25, 1984. At issue is the apportionment of liability between the two insurers.

Defendant asserts that its policy was a medical insurance policy with a coordination-of-benefits provision which specifically stated that if the insured had no-fault auto insurance, the auto insurance carrier would be liable for no-fault benefits. Since the insureds in the instant case had no-fault insurance, defendant reasons that, under the clear language of its policy, plaintiff is primarily responsible for the payment of no-fault benefits.

Plaintiff, on the other hand, contends that, since no-fault insurance is compulsory and the health insurance provided by defendant is not, the coordination-of-benefits clauses in

its policies should take precedence over and supersede the coordination-of-benefits clause in defendant's policy.

Section 3109a of the no-fault act, MCL 500.3109a; MSA 24.13109(1), requires insurers providing personal protection insurance to offer coordination-of-benefits options to their insureds, at correspondingly reduced rates, which "coordinate" recovery under multiple policies and seek to obviate the potential for double recovery, thereby serving to reduce insurance costs.

In *Nyquist* v *Aetna Ins Co*, 84 Mich App 589;269 NW2d 687 (1978), aff'd 404 Mich 817; 280 NW2d 792 (1979), this Court held that an insured could coordinate his no-fault insurance benefits with Blue Cross & Blue Shield benefits. Further, in *LeBlanc* v *State Farm Mutual Automobile Ins Co*, 410 Mich 173; 301 NW2d 775 (1981), the Supreme Court held that an insured could also elect to coordinate his no-fault benefits with benefits provided under the Medicare program. Some confusion reigns, however, where the insurance policies at issue both contain coordination-of-benefits clauses.

In *Farm Bureau Mutual Ins Co* v *Horace Mann Ins Co*, 131 Mich App 98; 345 NW2d 655 (1983), *lv den* 419 Mich 880 (1984), this Court held that it is absurd to assume "that where conflicting 'other insurance' provisions exist by reason of overlapping coverages of the same occurrence [,] the provisions of one policy must yield to the provisions of the other". 131 Mich App 103, quoting from *Lamb Weston Inc* v *Oregon Automobile Ins Co*, 219 or 110, 128; 341 P2d 110, 118–119 (1959). This Court ruled that the conflicting clauses were to be declared repugnant and were to be rejected *in toto*. 131 Mich App 103–104. Once the conflicting clauses were disregarded, this Court found that both policies would clearly provide coverage and each insurer's liability would then be prorated based on the proportion of the combined policy limits represented by the limits of each insurer's policy. *Farm Bureau*, however, did not involve no-fault insurance.

In *Mary Free Bed Hospital & Rehabilitation Center* v *Ins Co of North America*, 131 Mich App 105; 345 NW2d 658 (1983), *lv den* 419 Mich 943 (1984), this Court relied upon *Farm Bureau, supra,* in reaching the same result. *Mary Free Bed* also did not involve no-fault insurance.

In *United States Fidelity & Guaranty Co* v *Group Health Plan of Southeast Michigan*, 131 Mich App 268; 345 NW2d 683 (1983), this Court again addressed the question of how conflicts between coordination-of-benefits clauses should be resolved. There, a no-fault insurance policy and the provisions of a group subscriber contract with a health maintenance organization were at issue. However, this Court found that there was no true conflict between the clauses because the plaintiff no-fault insurer's "excess clause" clearly indicated that benefits were not available if there was other insurance. On the other hand, the Court ruled that the defendant's "excess clause" only provided that its benefits "may be reduced" if other insurcne was available. In addition, defendant's policy was unclear as to whether the claimant must merely qualify for or actually receive other benefits for the coordination-of-benefits provision to operate. Because of the clarity of plaintiff's excess clause, coupled with the ambiguity contained in defendant's, this Court concluded that the defendant should be held primarily liable. No reliance was placed on *Farm Bureau, supra,* or *Mary Free Bed, supra.*

In *Federal Kemper Ins Co, Inc.* v *Health Ins Administration, Inc.* 135 Mich App 76; 351 NW2d 900 (1984), plaintiff was the claimant's no-fault insurance carrier at the time of the injury. The defendant provided the claimant with health insurance under a group policy. Plaintiff paid the claimant's medical bills arising out of an automobile accident, but defendant refused to reimburse it for those payments. Both the plaintiff and the defendant claimed that is was a secondary insurer relative to the other. The plaintiff's insurance contract provided that it would not pay benefits to the extent that benefits were paid or payable for allowable expenses

under the provisions of any other insurance. On the basis of this Court's ruling in *Farm Bureau, supra*, the *Kemper* Court ruled that both the plaintiff and the defendant were liable for benefits to the claimant, prorated as to the proportion of the combined policy limits represented by the limits of each insurer's policy.

While the above-cited cases have reached reasonable results, we choose not to follow them here inasmuch as the legislative history surrounding the enactment of § 3109a does not appear to have been relied upon or addressed in those cases. In their briefs, the instant parties essentially argued various policy considerations in support of their respective positions, neither party seeking the result obtained in *Farm Bureau, supra*, and *Kemper, supra*, which prorated liability based on policy limits. At oral argument, however, plaintiff cited this Court's decision in *Dean* v *Auto Club Ins Ass'n*, 139 Mich App 266; 362 NW2d 247 (1984), which extensively discussed the legislative history of § 3109a. In reviewing this history as discussed in *Dean, supra*, and in *LeBlanc* v *State Farm, supra*, and *Nyquist* v *Aetna, supra*, we conclude that it evinces a clear legislative intent that the no-fault insurer provide only secondary coverage under § 3109a.

1974 House Bill 5724 was enacted into 1974 PA 72, the present MCL 500.3109a: MSA 24.13109(1). The analysis of HB 5724 prepared by the House Insurance Committee set forth several arguments in support of, and in opposition to, the bill. Each argument, however, proceeded from the premise that the coordination of benefits envisioned by the bill would make health and accident insurance, including that provided by Blue Cross & Blue Shield of Michigan, the primary coverage. The following concerns were expressed (and positions taken) in the analysis with respect to § 3109a:

"*Background Information:*

"Currently 4 of the 283 auto insurance companies doing business in Michigan offer deductibles or exclusions which cover only those items not covered by the policy holder's health and accident insurance. (These 4 auto-insurers *offer the secondary or 'wrap-around' coverage.)*

"Last September, Blue Cross/Blue Shield filed modifications with the Insurance Bureau proposing to allow its membrs to coordinate their medical benefits with their auto coverage by making the no-fault coverage primary and the Blues coverage wrap-around or the secondary coverage.

"*Argument For:*

"The bill would save millions of dollars for Michigan drivers and would offer them an opportunity to elilminate their duplicate, overlapping insurance coverage *since automobile insurers would be required to offer deductibles or exclusions which wrap-around a policy holder's health and accident coverage.* No-fault insurers would offer these deductions at reduced premiums, and State insurance officials estimate the 5 to 6 million Michigan drivers could save $100 million annually.

"*Argument For:*

"Passage of the bill would create more flexibility in health and accident coverage by offering consumers an insurance option which the vast majority of underwriters operating in Michigan do not offer. Further, if the Blue Cross/Blue Shield plans gain approval for their proposed modifications, the consumer seeking health and accident coverage will have yet another option from which to choose. The bill does not make it mandatory for an insurance buyer to select these deductibles and exclusions so many could still opt for overlapping coverage.

"*Argument For:*

"*The skyrocketing hospital and medical costs could be contained to a greater extent with health and accident as the primary coverage* since these policies, like the Blue Cross/Blue Shield plans, have established limits on their reimbursement of doctor and hospital expenses. A physician who knows his or her patient has unlimited medical coverage has no incentive to keep the doctor bill at a minimum.

"*Argument Against:*

"The efficiency and ease with which the no-fault statutes have been applied would be hampered by the bill, and insurance premiums could actually rise rather than decline. In lieu of automatic, fully comprehensive coverage by the auto insurer (under no-fault), *under the proposed wrap-around deductibles,* both the no-fault insurer and the health and accident company would be required to devote extra time and money to investigate an accident claim. They would have to reach an agreement to the extent to which each is responsible to the injured person. The rapid simplified reparations which have thus far characterized no-fault settlements would be bogged down by this process of double investigation and adjustment.

"*Argument Against:*

"No-fault insurers would be unable to establish fair and equitable rates since *the multitude of wrap-around combinations would make it impossible to determine a schedule for the proposed deductibles and exclusions.* No-fault is only 4 months old and insurance companies have yet to accumulate enough data to establish those premiums confidently. Spokesmen for the industry claim 18 months of data are necessary for the establishment of accurate premiums for a specific no-fault policy.

"*Argument Against:*

"*Required secondary coverage by no-fault providers* raises many ambiguities concerning the insurance statutes since no-fault is, by law, a mandatory requirement. Persons who reduce their no-fault medical coverage and then change jobs, or become unemployed, or those who misrepresent their accident and health coverage could be left without the minimum coverage required by the no-fault statutes.

"*Argument Against:*

"*Primary coverage by health and accident insurers would weaken the coverage on many persons* and would serve to confuse policyholders since it would substitute unknown, variable, noncompulsory benefits for compulsory, definitive and standardized benefits. No-fault is specifically designed to cover automobile accidents and injuries, offering the same basic coverage for everyone, but the accident and health insurers as well as Blue Cross/Blue Shield provide a puzzling number of alternative coverages, none of which are *[sic]* as complete and comprehensive as those of no-fault.

"*Argument Against:*

"*The bill discriminates against auto personal injury protection (no-fault) insurers since it does not require the accident and health insurers or Blue Cross/Blue Shield plans to offer similar deductibles to persons desiring to make their comprehensive no-fault policies primary, with other coverages being secondary.* If the intent of the bill is to save money for the consumer by offering a maximum of alternatives at reduced premiums, then health carriers should also be compelled to offer wrap-around coverage. *If accident and health coverage were made secondary, the reduction in premiums would be much larger,* particularly for persons whose policies include coverage for many dependents.

"*Neutral Discussion (Proposed Amendments):*

"The Michigan Association of Insurance Companies suggests offering consumers another alternative by requiring health and accident insurers (by statute) to offer at reduced rates, deductibles and exclusions to persons already covered under no-fault." (Emphasis added.)

As is manifest from the legislative analysis, § 3109a was intended to offer an option to no-fault consumers to allow them to make their no-fault coverage *secondary.* We find this conclusion inescapable from the concerns expressed.

Furthermore, a letter to Governor William G. Milliken from Daniel J. Demlow, the Commissioner of Insurance, dated February 26, 1974, also evinces a similar understanding as to HB 5724. Therein the commissioner noted that the "bill gives each consumer the chance to select or reject deductibles *based on his existing non-automotive health and accident coverage*". (Emphasis added).[1] This statement makes sense only if health and accident insurance is considered primary.

Additionally, the Supreme Court in *LeBlanc, supra*, pp 202-203, had the following to say concerning the above analysis of HB 5724:

> "The analysis of HB 5724 prepared by the House Insurance Committee indicates that *the bill would eliminate duplicate coverage by making private accident and health insurance, as well as the group plans of Blue Cross and Blue Shield, primary sources of reimbursement for accident-related medical and hospital expense.*" (Emphasis added.)

As further support for this conclusion, we look to the general purpose of § 3109a. It has been stated that § 3109a was designed to "contain or reduce insurance costs", *LeBlanc, supra*, p 197, and "was ° ° ° concerned with the rising cost of health care". *Dean, supra*, p 273. These two objectives are best fulfilled where health and accident insurance is primary, since, as noted in the analysis, "these policies, like Blue Cross/Blue Shield plans, have established limits on their reimbursement of doctor and hospital expenses". By contrast, expenses paid by no-fault insurance are subject to no such limits. To effectuate the intent of the Legislature in containing insurance costs in general, and health care costs in particular, health and accident insurance must be deemed primary.

In the instant case, we are unaware of the complete nature of defendant's policy. The lower court record contains only

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[1] See *LeBlanc v State Farm, supra*, pp 194-195, for further excerpts of this letter.

an excerpt of the page of defendant's policy on which the coordination-of-benefits clause is placed.[2] Defendant advances no statutory support for its attempt to make no-fault coverage primary,[3] nor is there evidence on the record that the approval of the Insurance Commissioner has been requested or granted with respect to this clause.[4] There is further no evidence that defendant's coordination-of-benefits clause was offered in such a way as to foster consumer savings, a major

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[2] Defendant's coordination-of-benefits clause provides:

"Section 23

"Co-ordination of Benefits

"In addition to the benefits payable under this plan, sometimes an employee or dependent is entitled to benefits for the same hospital or medical expenses under group fault or no-fault auto insurance, individual no-fault auto insurance, medicare or another group plan. Should this type of duplication occur, the benefits under this plan will be co-ordinated so that the total benefits from all plans will not exceed the hospital or medical expenses actually incurred. *In all cases employees with no-fault auto insurance coverage, the auto insurance carrier will be primary.*"

[3] We note parenthetically that 1984 PA 64, MCL 550.251 *et seq.*; MSA 24.13671 *et. seq.*, the Coordination of Benefits Act, in conjunction with 1984 PA 65 through 70, addresses the problem of overlapping benefits (and the coordination thereof) *among group health policies*. These acts provided for a standardized order of benefit determination among such group health policies in the areas of group disability (Act 65, MCI 500.3609a *et seq.*; MSA 24.13609 [1] *et. seq.)*, group policies of a health care corporation (Act 66, MCL 550.1401 *et seq.*; MSA 24.660 [401] *et seq.)*, group policies of a medical care corporation (Act 67, MCL 550.313b; MSA 24.603[2]), group policies of a hospital service corporation (Act 68, MCL 550.510b; MSA 24.630[2]), the policies of health maintenance organizations (Act 69, MCL 333.21074; MSA 14.15 [21074]), and of dental care corporations (Act 70 MCL 550.369a; MSA 24.650[19a]). Section 2(i) of 1984 PA 64, however, defines "policy" in such a way *(i.e.*, "a group disability insurance policy",) that no-fault insurance is not included. The analysis performed on 1984 Senate Bill 363 (enacted into 1984 PA 64) by the Senate Commerce Committee is also silent as to no-fault insurance.

[4] See *Siller v Employers Ins of Wausau*, 123 Mich App 140, 142; 333 NW2d 197 (1983). It is also noteworthy that MCL 500.3438, 500.3440; MSA 24.13438, 24.13440, which provide for the coordination of benefits in certain insurance contracts, similarly do not apply to no-fault insurance by virtue of MCL 500.3400(4); MSA 24.13400(4) and MCL 500.3600(1); MSA 24.13600(1). In view of the pervasiveness of the regulatory scheme existing with respect to coordination of benefits as contained in these sections, as well as those sections discussed in note 3, *supra*, in concert with the legislative history pertaining to 1974 PA 72, we believe that the new legislation's failure to coordinate such group health insurance with no-fault (and the similar failure of MCL 500.3438, 500.3440; MSA 24.13438, 24.13440) serves to indicate that no-fault coverage may not be made primary, *i.e.*, it is to be coordinated solely under the direction of § 3109a of the no-fault act.

goal of § 3109a, see analysis on HB 5724,*supra*, or as to how premiums or employee co-pay were affected by this clause to insure that defendant is not reaping unearned premiums. That is, because no-fault is mandatory and coordination of benefits must be offered *at a reduced rate*, the insured gains an advantage from such a clause by the required reduction in premium while the insurer's reduced profits reflect a corresponding reduction in its potential liability. No such check necessarily applies to health and accident insurance. It would not be difficult to simply insert a coordination-of-benefits clause in a health and accident policy without a corresponding reduction in premium or co-pay where the determination of primary liability is governed by the policy language.

In an area such as no-fault insurance and, for that matter, health insurance as well, where the regulatory scheme established by the Legislature is of such a pervasive nature, we agree with plaintiff that the clarity of policy language should not govern apportionment of liability.[5]

Reversed and remanded for entry of judgment and determination of liability consistent with this opinion. No costs, a question of public significance being involved.

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[5] The result reached in this case is not necessarily in conflict with existing case law. As noted earlier, *Farm Bureau v Horace Mann*, *supra*, and *Mary Free Bed v INA*, *supra*, did not deal with no-fault insurance. *US Fidelity v GHP*, *supra*, while dealing with no-fault, did not involve conflicting clauses. And, although *Kemper v Health Ins*, *supra*, appears to be inconsistent, there is no indication that the parties raised the issue of legislative intent. Both parties ostensibly argued the respective provisions in the insurance policies. In the case *sub judice*, however, plaintiff touched upon the relevant policy considerations in its brief and, at oral argument, specifically raised the intent of the Legislature as discussed in *Dean v Auto Club*, *supra*.

STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

AUTO CLUB INSURANCE ASSOCIATION, f/k/a D.A.I.I.E., Subrogee of Ali Chehab; Faysal Mazloum; Nouhad Jamil Bazzi; Hussein H. Habab; Nasri Jomaa; Ali K. Hashem; and Sami M. Alaouie, et al,
Plaintiffs

-vs-

FREDERICK AND HERRUD, INC., a corporation,
Defendant

No. 82-246269-CK

Hon. FREDERICK ZIEM

JOHN WESLEY KLINE (P 33150)
Attorney for Plaintiff

JAMES M. RIFKIN (P 19442)
Attorney for Defendant

ORDER OF SUMMARY JUDGMENT

At a session of the Court held in the City of Pontiac, County of Oakland, and State of Michigan on June 25, 1984.

PRESENT: HON. FREDERICK C. ZIEM
CIRCUIT COURT JUDGE

IT IS HEREBY ORDERED that the Motion for Summary Judgment submitted to this Court for consideration by the Plaintiff and by the Defendant are decided as follows:

The parties in this action are found to be in equal priority to pay the benefits of their respective insureds.

WHEREFORE the Defendant is ordered to reimburse to the Plaintiff 50% of all monies paid as benefits to the insureds involved in this action.

/s/ FREDERICK C. ZIEM
CIRCUIT COURT JUDGE

Prepared by:
/s/ JOHN WESLEY KLINE
John Wesley Kline
Attorney for Plaintiff

Approved by:
/s/ JAMES M. RIFKIN
James M. Rifkin
Attorney for Defendant

STATUTES INVOLVED

The relevant provisions of the Employee Retirement Income Security Act of 1974, as amended, are set forth below:

Section 502, 29 U.S.C. § 1132.

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought —

(1) by a participant or beneficiary —

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter; or

(6) by the Secretary to collect any civil penalty under subsection (i) of this section.

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(d) Status or employee benefit plan as entity

(1) An employee benefit plan may sue or be sued under this subchapter as an entity. Service of summons, subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter.

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, or fiduciary. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under subsection (a)(1)(B) of this section.

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Section 514, 29 U.S.C. § 1144.

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw.Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section—

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent thay govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts.

(6)(A) Notwithstanding any other provision of this section—

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangment subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides—

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangment, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) shall not apply to qualified domestic relations orders (within the meaning of section 1056(d)(3)(B)(i) of this title).

(8) Subsection (a) of this section shall not apply to any State law mandating that an employee benefit plan not include any provision which has the effect of limiting or excluding coverage or payment for any health care for an individual

who would otherwise be covered or entitled to benefits or services under the terms of the employee benefit plan, because that indivudal is provided, or is eligible for, benefits or services pursuant to a plan under title XIX of the Social Security Act [42 U.S.C.A. § 1396 et seq.], to the extent such law is necessary for the State to be eligible to receive reimbursement under title XIX of that Act.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

The relevant provision of the Michigan No-Fault Insurance Act is set forth below:

Mich. Comp. Laws Ann. § 500.3109a

Sec. 3109a. An insurer providing personal protection insurance benefits shall offer, at appropriately reduced premium rates, deductibles and exclusions reasonably related to other health and accident coverage on the insured. The deductibles

and exclusions required to be offered by this section shall be subject to prior approval by the commissioner and shall apply only to benefits payable to the person named in the policy, the spouse of the insured and any relative of either domiciled in the same household.